STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORE NURSING & REHABILITATION	909 FIRST AVE EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a recertification and state licensure survey. This visit included the investigation of complaint number IN00088824. Complaint number: IN00088824, substantiated, no deficiencies related to the allegations are cited. Survey Dates: April 12, 13, 14, 15, 18, 20, 2011 Facility Number: 000437 Provider Number: 155520 AIM Number: 100273770 Survey Team: Sue Webster, RN TC Diane Hancock, RN Jodi Meyer, RN 4/12/11 Amy Wininger, RN 4/12, 4/13, 4/14, 4/18, 4/20, 2011 Census Bed Type: SNF/NF= 17 NF= 44 Total= 61 Census Payor Type: Medicare= 3 Medicaid= 54	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Other= 4 Total: 61 Sample: 15 Supplemental Sample: 1 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 3-26-11 Cathy Emswiller RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to ensure a physician was notified of a resident's use of routine pain medication, when he was routinely receiving as needed pain medication, for 1 of 1 supplemental sample resident reviewed for pain, in the supplemental sample of 1. (Resident #23)	F0157	This facility will ensure the resident, their legal representative and physician are notified of the resident(s) routine PRN pain medication administration.A pain assessment was completed for Resident #23 on April 18, 2011, the resident's physician was notified and a physician's order was recived on April 19, 2011 for	05/20/2011

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	Finding includes: During initial tour, on 04/12/11 at 1:15 P.M., during interview, RN #1 indicated Resident #23 was not interviewable, required total assistance for care, and was transferred by Hoyer [mechanical] lift. The clinical record of Resident #23 was reviewed on 04/18/11 at 10:30 A.M. Resident #23's diagnoses included, but were not limited to, Alzheimer's disease, arthritis, and osteoporosis. The most current MDS [Minimum Data Set Assessment], dated 02/24/11, indicated that Resident #23 was severely cognitively impaired, had not been on a scheduled pain med regimen, had received PRN [as needed] pain medication, and there was no presence of pain. A Care Plan, updated on 02/15/11, for "Self-care deficit r/t decreased physical and cognitive ability et endurance," indicated, "...19. Monitor for signs/symptoms of pain...and take appropriate action." A Nursing Progress Note, for the observation period of 02/10/11 to 02/16/11, indicated Resident #23 was alert to self, and lacked any documentation of		Lortab 7.5 mg p.o. BID and Mobic 7.5 mg p.o. qd to assist in pain management. The resident's legal representative was notified regarding the resident's change in medication. All licensed nurses were inserviced on May 6, 2011 on their responsibility in monitoring and communicating the use of PRN pain medication to assist in pain management. The inservices also included the importance of notification being provided to the resident, their legal representative and their attending physician. A new pain management form has been developed along with a quarterly assessment tool and weekly monitoring tool. Each unit manager will inform the interdisciplinary team members weekly during the at-risk meeting of PRN medication use frequency and explanation. This information will assist the resident and the IDT members in interventions to assist in pain management.A review of all medical records was conducted on April 22, 2011 of all residents receiving PRN pain medication(s). All pain assessments have been reviewed and updated. It was determined that no additional residents have been negatively affected.A pain assessment has been completed for each resident receiving routine and/or PRN pain medication by the MDS Coordinator to monitor the frequency of use, the explanation of use, interventions	

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	pain assessment. In an interview with LPN #3, on 04/18/11 at 12:15 P.M., she indicated, "The last time I did a pain assessment was March 2010. I do the interview on the new MDS quarterly....He said he wasn't in pain when I interviewed him." A Nursing Note dated 03/16/10 and attached to the pain assessment indicated, "Res continues to require prn Lortab almost daily times one dose for bil [bilateral] knee pain with effective results. Will continue to monitor for adeq [adequate] level of comfort." The February 2011 MAR [Medication Administration Record] was reviewed, on 04/18/11 at 1:00 P.M., and indicated Resident #23 used Lortab 7.5-500 fifteen times in 24 days as follows: 02/03/11 at 8:00 A.M. for "pain." 02/04/11 at 7:30 A.M. and 8:00 P.M. for "lower back pain." 02/05/11 at 8:00 A.M. for "bilateral knee pain." 02/05/11 at 8:00 P.M. for "bilateral knee pain." 02/06/11 at 8:00 P.M. for "bilateral knee pain." 02/09/11 at 8:45 P.M. for "rubbing knees moaning." 02/12/11 at 8:00 P.M. for "bilateral knee		and effectieness. A weekly monitoring tool has been developed for each Unit Manager to thoroughly assess the frequency, explanation, interventions and effectiveness which will be discussed weekly with the IDT members at the at-risk meeting. The monitoring tool will be provided to the Director of Nursing for input as to the effectiveness. This information will be discussed quarterly with the Quality Improvement Committee. The MDS Coordinator will update the pain assessment and evaluate pain medication use for the last 90 days (using the quarterly pain evaluation form) for effectiveness.The Director of Nursing assumes responsibility and wilol monitor weekly through the monitoring tool provided by each Unit Manager. This monitoring will become part of the weekly at-risk meeting agenda and will be ongoing for the remainder of 2011.	

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	pain." 02/13/11 at 8:00 P.M. for "bilateral knee pain." 02/19/11 at 8:00 P.M. for "bilateral knee pain." 02/20/11 at 8:00 P.M. for "bilateral knee pain." 02/21/11 at 9:00 A.M. for "bilateral knee pain." 02/23/11 at 9:00 A.M. for "rubbing knees moaning. Asked if in pain states 'yeah.'" 02/23/11 at 8:00 P.M. for no reason specified. 02/26/11 at 8:00 P.M. for "bilateral knee pain." 02/27/11 at 8:00 P.M. for "bilateral knee pain." The March 2011 MAR was reviewed on 04/18/11 at 1:00 P.M. and indicated Resident #23 used Lortab 7.5-500 fifteen times in 24 days on: 03/05/11 at 8:00 A.M. and 8:00 P.M. for bilateral knee pain. 03/06/11 at 8:00 A.M. and 8:00 P.M. for "bilateral knee pain." 03/08/11 at 8:00 A.M. for "knee pain." 03/09/11 at 8:00 P.M. for "knee and leg pain." 03/10/11 at 9:30 P.M. for "knee and leg pain." 03/12/11 at 8:00 P.M. for "knee pain." 03/13/11 at 8:00 P.M. for "knee pain." 03/14/11 at 7:45 P.M. for "knee pain."			

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	03/19/11 at 8:00 P.M. for "knee pain." 03/20/11 at 8:00 P.M. for "knee pain." 03/21/11 at 8:45 A.M. for "rubbing knees and moaning." 03/22/11 at 9:00 A.M. for "knee pain." 03/23/11 at 8:45 A.M. for "bilateral knee pain." 03/26/11 at 8:00 P.M. for "bilateral knee pain." 03/29/11 at 8:00 P.M. for "bilateral knee pain." The April 2011 MAR was reviewed on 04/18/11 at 1:00 P.M. and indicated Resident #23 used Lortab 7.5-500 eleven times in 15 days on: 04/02/11 at 8:00 A.M. for "moaning loudly suspect pain ." 04/02/11 at 8:00 P.M. for "knee pain." 04/03/11 at 8:00 A.M. for "moaning loudly as in pain." 04/04/11 at 8:00 A.M. for "bilateral knees hurting." 04/05/11 at 12:35 P.M. for "rubbing knees and moaning." 04/06/11 at 4:30 P.M. for "rubbing knees." 04/09/11 at 8:00 P.M. for "knee pain." 04/10/11 at 8:00 P.M. for "knee pain." 04/16/11 at 8:00 A.M. for "bilateral knee pain." 04/16/11 at 8:30 P.M. for "moaning, knee pain." 04/17/11 at 8:00 P.M. for "moaning			

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	rubbing knees." A MDS assessment, provided by LPN [Licensed Practical Nurse] #3 on 04/18/11 at 12:25 P.M. and identified by LPN #3 as a worksheet, indicated Resident #23 had not been experiencing pain in the last 5 days, with a handwritten notation, "states 'no.'" There was no indication the LPN had evaluated the resident's regular use of prn pain medication for pain, or evaluated the resident for use of routine pain medication due to his near daily use of as needed pain medication. The Policy and Procedure for Pain Management, provided by the DoN on 04/18/11 at 5:43 P.M., indicated, "...All resident will be assessed for pain control needs upon admission and quarterly thereafter utilizing the Pain Assessment form...Resident(s) pain management program/effectiveness will be evaluated ...quarterly by the MDS coordinator. Quarterly the MDS coordinator will update the pain assessment and review pain medication use for the last 90 days." 3.1-5(a)(3)			

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on observation, interview and record review, the facility failed to ensure a resident was assessed for and provided routine pain medication, when he was routinely receiving as needed pain medication, for 1 of 1 supplemental sample resident reviewed for pain, in the supplemental sample of 1. (Resident #23)	F0272	This facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity ensuring that each resident is assessed for and provided routing pain medication when they are routinely receiving PRN pain medication.The pain assessment was reviewed and updated for Resident #23 on April	05/20/2011

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	Finding includes: During initial tour, on 04/12/11 at 1:15 P.M., upon interview RN #1 indicated Resident #23 was not interviewable, required total assistance for care, and was transferred by Hoyer [mechanical] lift. The clinical record of Resident #23 was reviewed on 04/18/11 at 10:30 A.M. Resident #23's diagnoses included, but were not limited to, Alzheimer's disease, arthritis, and osteoporosis. Resident #23 was observed, on 04/18/11 at 10:00 A.M., being transferred from a wheelchair to a commode by CNA [Certified Nursing Assistant] #1 and CNA #2, using a gait belt. The most current MDS [Minimum Data Set Assessment], dated 02/24/11, indicated that Resident #23 was severely cognitively impaired, had not been on a scheduled pain med regimen, had received PRN [as needed] pain medication, and there was no presence of pain. A Care Plan, updated on 02/15/11, for "Self-care deficit r/t decreased physical and cognitive ability et endurance," indicated, "...19. Monitor for signs/symptoms of pain...and take		19, 2011, the resident's physician was notified and a physician't order was received for Lortab 7.5 mg p.o. BID and Mobic 7.5 mg p.o. qd to assist in pain management. The resident's legal representative was notified regarding the resident's change in medication.All licensed nurses were inserviced on May 6, 2011 on their responsibility in monitoring and communicating the use of PRN pain medication to assist in pain management. A new pain assessment form has been developed along with a quarterly assessment and weekly monitoring tool. Each unit manager will inform the interdisciplinary team weekly during the at-risk meeting of PRN medication use frequency and explanation of use. This information will assist the resident and the IDT members in interventions to assist in pain management.Resident #23 was evaluated for physical function on april 26, 2011 and it was determined that he requires a mechanical lift for all transfers to assist in pain reduction/management of bi-lateral knee pain. CNAs were inserviced on May 6, 2011 on the importance of the resident care information sheet and following the resident's plan of care designated on the CNA assignment sheet.A review of all medical records was conducted on April 22, 2011 of all residents	

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	appropriate action." A Nursing Progress Note, for the observation period of 02/10/11 to 02/16/11, indicated Resident #23 was alert to self, and lacked any documentation of pain assessment. In an interview with LPN #3, on 04/18/11 at 12:15 P.M., she indicated, "The last time I did a pain assessment was March 2010. I do the interview on the new MDS quarterly....He said he wasn't in pain when I interviewed him." A Nursing Note dated 03/16/10 and attached to the pain assessment indicated, "Res continues to require prn Lortab almost daily times one dose for bil [bilateral] knee pain with effective results. Will continue to monitor for adeq [adequate] level of comfort." The February 2011 MAR [Medication Administration Record] was reviewed, on 04/18/11 at 1:00 P.M., and indicated Resident #23 used Lortab 7.5-500 fifteen times in 24 days as follows: 02/03/11 at 8:00 A.M. for "pain." 02/04/11 at 7:30 A.M. and 8:00 P.M. for "lower back pain." 02/05/11 at 8:00 A.M. for "bilateral knee pain." 02/05/11 at 8:00 P.M. for "bilateral knee		receiving PRN pain medication(s). A pain assessment has been completed and a thorough review of the frequency of use of PRN pain medications, the explanation of use, interventions and effectiveness. It has been determined that four (4) additional residents had the potential to be effected. These residents along with resident #23 will continue to be monitored weekly by the Unit Manager and the Director of Nursing.A pain assessment has been completed for each resident receiving routine and/or PRN pain medication by the MDS Coordinator to monitor the frequency of use, the explanation of use, interventions and effectiveness. A weekly monitoring tool has been developed for each Unit manager to thoroughly assess the frequency, explanation, interventions and affectiveness which will be discussed with the IDT members weekly during the at-risk meeting. The monitoring tool will be provided to the Director of Nursing for input as to the effectiveness. This information will be discussed quarterly with the Quality Improvement Committee. The MDS Coordinator will update the pain assessment and evaluate pain medication use for the last 90 days (using the quarterly pain evaluation form) for effectiveness. The Director of	

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	pain." 02/06/11 at 8:00 P.M. for "bilateral knee pain." 02/09/11 at 8:45 P.M. for "rubbing knees moaning." 02/12/11 at 8:00 P.M. for "bilateral knee pain." 02/13/11 at 8:00 P.M. for "bilateral knee pain." 02/19/11 at 8:00 P.M. for "bilateral knee pain." 02/20/11 at 8:00 P.M. for "bilateral knee pain." 02/21/11 at 9:00 A.M. for "bilateral knee pain." 02/23/11 at 9:00 A.M. for "rubbing knees moaning. Asked if in pain states 'yeah.'" 02/23/11 at 8:00 P.M. for no reason specified. 02/26/11 at 8:00 P.M. for "bilateral knee pain." 02/27/11 at 8:00 P.M. for "bilateral knee pain." The March 2011 MAR was reviewed on 04/18/11 at 1:00 P.M. and indicated Resident #23 used Lortab 7.5-500 fifteen times in 24 days on: 03/05/11 at 8:00 A.M. and 8:00 P.M. for bilateral knee pain. 03/06/11 at 8:00 A.M. and 8:00 P.M. for "bilateral knee pain." 03/08/11 at 8:00 A.M. for "knee pain." 03/09/11 at 8:00 P.M. for "knee and leg		Nursing assumes responsibility and will monitor weekly through the monitoring tool provided by each Unit Manager. This monitoring will become part of the weekly at-risk meeting agenda and will be ongoing for the remainder of 2011.	

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	pain." 03/10/11 at 9:30 P.M. for "knee and leg pain." 03/12/11 at 8:00 P.M. for "knee pain." 03/13/11 at 8:00 P.M. for "knee pain." 03/14/11 at 7:45 P.M. for "knee pain." 03/19/11 at 8:00 P.M. for "knee pain." 03/20/11 at 8:00 P.M. for "knee pain." 03/21/11 at 8:45 A.M. for "rubbing knees and moaning." 03/22/11 at 9:00 A.M. for "knee pain." 03/23/11 at 8:45 A.M. for "bilateral knee pain." 03/26/11 at 8:00 P.M. for "bilateral knee pain." 03/29/11 at 8:00 P.M. for "bilateral knee pain." The April 2011 MAR was reviewed on 04/18/11 at 1:00 P.M. and indicated Resident #23 used Lortab 7.5-500 eleven times in 15 days on: 04/02/11 at 8:00 A.M. for "moaning loudly suspect pain ." 04/02/11 at 8:00 P.M. for "knee pain." 04/03/11 at 8:00 A.M. for "moaning loudly as in pain." 04/04/11 at 8:00 A.M. for "bilateral knees hurting." 04/05/11 at 12:35 P.M. for "rubbing knees and moaning." 04/06/11 at 4:30 P.M. for "rubbing knees." 04/09/11 at 8:00 P.M. for "knee pain."			

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	04/10/11 at 8:00 P.M. for "knee pain." 04/16/11 at 8:00 A.M. for "bilateral knee pain." 04/16/11 at 8:30 P.M. for "moaning, knee pain." 04/17/11 at 8:00 P.M. for "moaning rubbing knees." An MDS assessment, provided by LPN [Licensed Practical Nurse] #3 on 04/18/11 at 12:25 P.M. and identified by LPN #3 as a worksheet and dated , indicated Resident #23 had not been experiencing pain in the last 5 days, with a handwritten notation, "states 'no.'" There was no indication the LPN had evaluated the resident's regular use of prn pain medication for pain, or evaluated the resident for use of routine pain medication due to his near daily use of as needed pain medication. The Policy and Procedure for Pain Management, provided by the DoN on 04/18/11 at 5:43 P.M., indicated, "...All resident will be assessed for pain control needs upon admission and quarterly thereafter utilizing the Pain Assessment form...Resident(s) pain management program/effectiveness will be evaluated ...quarterly by the MDS coordinator. Quarterly the MDS coordinator will update the pain assessment and review			

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	pain medication use for the last 90 days." 3.1-31(a)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. During observation, interview and record review, the facility failed to ensure a resident who required a mechanical lift for transfers was transferred according to the plan of care, in that the resident was transferred from a wheelchair to a commode without the use of a mechanical lift, for 1 of 1 supplemental sample resident in the supplemental sample of 1 reviewed for Hoyer transfer. (Resident #23) Finding includes: During initial tour, on 04/12/11 at 1:15 P.M., RN #1 indicated Resident #23 was not interviewable, and was transferred by Hoyer [mechanical] lift. The clinical record of Resident #23 was reviewed on 04/18/11 at 10:30 A.M. Resident #23's diagnoses included, but were not limited to, Alzheimer's, arthritis,	F0282	This facility will ensure any resident requiring a mechanical lift for transfers is transferred according to their plan of care.Resident #23 was evaluated for physical function on April 26, 2011 and it was determined that he requires a mechanical lift for all transfers to assist in pain reduction/management of bi-laterlal knee pain. CNAs were inserviced on may 6, 2011 on the importance of the resident care information sheet and folloiwng the resident's plan of care communicated via the CNA Assignment sheet.All residents utilizing a mechanical lift for transfers were reviewed. Their care plans, CNA Assignment Sheet, Resident Care Information Sheet were reviewed for accuracy and consistency. Interviews with CNAs along with actual visual checks were performed to determine the mechanical lift was being utilized for all transfers. It was determined there were no other residents negatively	05/20/2011

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	and osteoporosis. Resident #23 was observed, on 04/18/11 at 10:00 A.M., being transferred from a wheelchair to a commode by CNA [Certified Nursing Assistant] #1 and CNA #2 using a gait belt. A mechanical lift sling was noted underneath the resident at that time. The most current MDS [Minimum Data Set Assessment], dated 02/24/11, indicated that Resident #23 was severely cognitively impaired, was completely dependent for toilet use, personal hygiene, and had range of motion limitations to the bilateral lower extremities. A Care Conference Summary, dated 02/23/11, indicated Resident #23 was "dependent for all care." A Care Plan, updated on 02/15/11, for "Self-care deficit r/t [related to] decreased physical and cognitive ability et endurance to activity with dependence on staff with all transfers/mobility. Use of mechanical lift for transfers...Approaches...13. Staff assist of 2 et[and] use of mechanical lift with all transfers..." A Resident Care Information Form, updated on 04/05/11, indicated Resident		affected.CNAs were inserviced on May 6, 2011 on the importance of the resident care information sheet and the CNA Assignment sheet. A daily monitoring form has been developed to assist the charge nurse in monitoring all residents requiring a mechanical lift for transfers to ensure the lift is being utilized for all transfers. The charge nurse will monitor daily for compliance with each resident requiring a mechanical lift for transfers. This completed monitoring tool will be given to the Director of Nursing weekly for review. Residents requiring a mechanical lift will be discussed weekly with the IDT members at-risk meeting. The charge nurse will monitor daily for the first three (3) months and then weekly for the remainder of 2011.The Director of Nursing assumes responsibility and will utilize the mechanical lift monitoring tool to report to the Quality Improvement Committee at least quarterly to ensure that all residents requiring the use of a mechanical lift for transfers are being transferred according to their plan of care established for that resident.	

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	#23 required a mechanical lift for transfers and was non-ambulatory." A Nursing Progress Note, dated 04/12/11 at 10:00 P.M., indicated "...up daily in wheelchair with mechanical lift for transfers..." An ADL [Activity of Daily Living] Functional/Restorative Assessment dated 02/15/11 indicated Resident #23 had no weight bearing ability to the Right or Left leg and required a Hoyer lift for transfers. An attendance roster for an inservice covering "ROM [Range of Motion], Gait training, Body Mechanics" was provided by the ADoN [Assistant Director of Nursing] on 04/18/11 at 5:05 P.M. and indicated CNA #1 and CNA #2 attended on 09/10/10. The inservice education piece included, but was not limited to, "Use a two-person transfer when a patient...at least 50% weight bearing. some two person transfers have been used when the patient is non-weight bearing, but this is not recommended..." The Policy and Procedure for "Using a Portable Lift Device" [no date] was provided by the DoN [Director of Nursing] on 04/18/11 at 5:43 P.M. and indicated, "Purpose: The purpose of using a portable lift device is to help lift resident			

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	who are non-weight bearing, dependent ...who are not able to move themselves..." The CNA Assignment Sheet, provided by RN #1 on 04/12/11 at 1:15 P.M., indicated Resident #23 required "total care...incontinent bowel and bladder, mechanical lift for transfers". In an interview with CNA #2, on 04/18/11 at 11:00 A.M., she indicated, "Peri-care [sic] should be given if they are incontinent, after they use the bathroom, and when we change them." In an interview with CNA #1 on 04/18/11 at 11:45 A.M. she indicated, "We get him [Resident #23] with the lift in the morning. They don't use the Hoyer to put him on the commode. The second shift uses the lift in the evening." In an interview with RN #1, on 04/18/11 at 12:00 P.M., she indicated, "We don't use the lift on [Resident #23] during the day, we use the gait belt." 3.1-35(g)(2)			

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F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to ensure residents who were dependent on staff for personal hygiene, were provided thorough perineal care following incontinence, for 1 of 5 sampled dependent residents reviewed for incontinence (Resident #77), in the total sample of 15, and for 1 of 1 supplemental sample resident reviewed for incontinence care, in the supplemental sample of 1 (Resident #23). Findings Include: 1. During initial tour, on 04/12/11 at 1:15 P.M., RN #1 indicated Resident #23 was not interviewable, required total assistance for care, and was transferred by Hoyer [mechanical] lift. The clinical record of Resident #23 was reviewed on 04/18/11 at 10:30 A.M. Resident #23's diagnoses included, but were not limited to, Alzheimer's, arthritis, and osteoporosis. Resident #23 was observed on 04/18/11 at 10:00 A.M. being assisted to the toilet. Resident #23 was observed to be incontinent of urine, requiring the	F0312	This facility will ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Ensuring resident(s) who are dependent upon staff for personal hygiene, were provided thorough perineal care following incontinence.CNAs #1, #2, #5, #6 received written disciplinary action for not following policy and procedure in providing proper perineal care for a dependent resident. CNAs were inserviced on May 6, 2011 on the proper procedures of performing perineal care following incontinence. This inservice will include, but not be limited to, step-by-step perineal care for male and female residents, return demonstration and the use of universal precatutions to prevent the spread of infection. An inservice for full-staff was held on April 22, 2011 on the importance of proper handwashing. A monitoring form was developed for each CNA to perform a return-demonstration for providing proepr perineal care for a dependent resident. This monitoring tool allows each CNA three (3) return demonstrations. The Director of Nursing or her designee will ensure that each CNA can demonstrate proepr	05/20/2011

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	incontinence brief to be changed. CNA #1 and CNA #2 were observed to provide no incontinence care to Resident #23, i.e. no cleansing of the skin in contact with the urine. The most current MDS [Minimum Data Set Assessment], dated 02/24/11, indicated Resident #23 was severely cognitively impaired, was always incontinent, was completely dependent for toilet use, and personal hygiene. A Care Conference Summary, dated 02/23/11, indicated Resident #23 was "dependent for all care." A Care Plan, updated on 02/15/11, for "Self-care deficit r/t [related to] decreased physical and cognitive ability ... Dependent for hygiene and bathing...Incontinent of Bowel and bladder with staff monitoring every 2 hours and prn [as needed] with hygiene provided as indicated...Approaches...18. Staff to monitor for incontinence every 2 hours and prn and provide hygiene as indicated." A Resident Care Information Form, updated on 04/05/11, indicated Resident #23 was "incontinent of urine and stool...provide pericare [sic]after incontinence."		step-by-step perineal care their their male and female resident(s). This monitoring tool will also be utilized in the future for newly hired CNAs to ensure they can demonstrate proper perineal care.There were no other residents negatively affected by this practice, although all incontinent residents had the potential to be affected.The perineal care policy and procedure has been updated. An inservice for all CNAs was held on ay 6, 2011 on the proper step-by-step procedures of performing perineal care for male and female residents. To pass, one successful return demonstration for both a female and male resident out of three (3) attempts are required by each CNA for the Director of Nursing or her designee. (i.e., The CNA must pass two (2) of the three (3) attempts ... one (1) being male and one (1) being female in order to remain employed in this facility). The monitoring tool will be utilized on each newly hired CNA to ensure they can demonstrate proper perineal care for both the male and female resident.The Director of Nursing assumes responsibility for compliance and will have each CNA return demonstrate proper step-by-step perineal care three (3) times. Should the CNA be unable to return demonstrate successfully three (3) times, their employment will be terminated.	

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	A Nursing Progress Note, dated 04/12/11 at 10:00 P.M., indicated, "...incontinent of bowel and bladder with peri care provided by staff." The CNA Assignment Sheet, provided by RN #1 on 04/12/11 at 1:15 P.M., indicated Resident #23 required "total care...incontinent bowel and bladder..." 2. On 11/18/11 at 11:45 a.m., CNAs #5 and #6 were observed turning and repositioning Resident #77. The resident had an indwelling urinary catheter. The resident was observed to have been incontinent of bowel. CNA #6 provided wet wash cloths to CNA #5. CNA #5 wore gloves and proceeded to clean the buttocks and peri-anal area. After she cleaned the area and put a clean underpad under the resident, they repositioned the resident onto her back and covered her up. At that time, CNA #5 was requested to check the resident's front perineal area. They uncovered the resident and checked. CNA #6 then obtained more wash cloths and wet them and handed them to CNA #5. She proceeded to wash off the resident's inner thighs and periarea. She was observed to wash forward and back		This monitoring tool will be utilized by the Director of Nursing or her designee on all new hires to ensure that all CNAs can demonstrate proper perineal care. This monitoring will be ongoing. The Director of Nursing will report her monitoring of perineal care to the Quality Improvement Committee at least quarterly. She will follow any recommendations that might be made. The perineal monitoring tool will be maintained by the Director of Nursing.	

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	and around the urinary catheter, removing brown soil from the resident. Following the procedure, CNA #6 took her gloves off and left the room. She was then questioned regarding the wash cloths. She indicated she had wet them with water and had not put any soap or periwash solution on the wash cloths. 3. The policy and procedure for Perineal Care [no date] was provided by the Director of Nurses on 4/18/11 at 5:40 p.m. The policy and procedure included, but was not limited to, the following: "Perineal care for female patients: -gather washcloth, dry towel(s) soap or periwash and bath basin, -fill the bath basin with clean water at 110 degrees, -separate the labia and wash, rinse and dry the urethral area first with short downward strokes alternating from side to side and proceeding until the exposed area around the urethra is done, -wash the groin on the outside of the labia from the front to the back starting outside the labia and then going to the inside of the thighs, -turn the person on their side, -and wash, rinse and dry the rectal and buttock area."			

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	An attendance roster for an inservice covering "Incontinent Care" was provided by the ADoN [Assistant Director of Nursing] on 04/18/11 at 5:05 P.M. and indicated CNA #1 and CNA #2 attended the inservice on 01/14/11. The inservice education piece included, but was not limited to, "Wipe front to back." In an interview with CNA #2 on 04/18/11 at 11:00 A.M. she indicated, "Peri-care [sic]should be given if they are incontinent, after they use the bathroom, and when we change them." 3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(C) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review, the facility failed to ensure perineal care was provided in a manner to prevent potential infections, and failed to ensure gloves were changed and hands	F0441	This facility has established an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and	05/20/2011

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	were washed between soiled and clean activities, during care observations for 3 of 13 sampled residents, in the sample of 15, and for 1 of 1 supplemental sample resident, in the supplemental sample of 1, in that perineal care was not thoroughly provided and/or was provided in a manner that could cause infection, and CNAs were observed to provide care and not change gloves and wash hands when potentially contaminated. (Residents #65, #77, #9, #23) Findings include: 1. On 4/13/11 at 9:10 a.m., CNA 6 was observed providing a bed bath to Resident #65. The bath water was in a wash pan on the overbed table. During the cleansing of the front perineal area, the CNA washed and rinsed from the back to the front. When the bath was completed, the CNA took the bath basin off of the overbed table and emptied the water. There was some residual water on the overbed table. The CNA positioned the resident, covered her, and left the room without sanitizing the overbed table. On 4/18/11 at 3:30 p.m., the observation was reviewed with the Director of Nurses. She indicated the CNAs should be sanitizing the overbed table if soiled with bath water.		transmission of disease and infection.The facility ensures that perineal care is provided in a manner to prevent potential infections, and ensures gloves are changed and hands are washed between soiled and clean activities.CNAs were inserviced on may 6, 2011 on Infection Control and the need to provide perineal care in a manner to prevent potential infections and ensure that gloves are changed and hands are washed between soiled and clean activities. To ensure that any equipment (i.e.,, over-the-bed table) used will be thoroughly cleaned after perineal care or bathing.CNAs #1, #2, #5, #6 received written disciplinary action for not following policy and procedure in providing proper perineal care for a dependent resident. CNAs were inserviced on May 6, 2011 on the proper procedures of performing perineal care following incontinence. This inservice included step-by-step perineal care for male and female residents, return demonstration and the use of universal precautions to prevent the spread of infection. An inservice for full-staff was held on April 22, 2011 on the importance of handwashing to prevent the spread of infection. A monitoring form was developed for each CNA to perform a return demonstration for providing proper perineal care for a dependent resident. This	

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	2. On 4/18/11 at 11:45 a.m., CNAs #6 and #5 were observed repositioning Resident #77. The resident had an indwelling urinary catheter. She had been incontinent of bowel. CNA #5 was observed to wear gloves; she cleansed the resident's buttocks and anal area by wiping stool several times from the area. After she used wet wash cloths to wipe the back side of the resident, she held the residents hand with the same gloved hand used to cleanse the resident and assisted the resident to turn onto her back. She then took the gloves off and used alcohol gel for hand hygiene. She covered up the resident and was prepared to leave the room. At that time, it was requested that she check the front perineal area. She uncovered the resident and checked. She then used wet wash cloths to remove residual stool from the front area. She was observed to wipe back and forth over the area and around the catheter, with potential for contamination of the area. CNA #6 assisted with the repositioning and care of the resident. She was observed to remove her gloves and exit the room. She went to the nurses' station and obtained some over the counter medication from RN #2's personal supply; the tablets were placed in her hand. She then went to the pantry to get some water. At that time, she was questioned about washing her hands. She indicated she would after she took the medication.		monitoring tool allows each CNA three (3) return demonstrations. The Director of Nursing or her designee will ensure that each CNA can demonstrate proper step-by-step perineal care fo rtheir male and female residents. This monitoring tool will also be utilized for all newly hired CNAs to ensure they can demonstrate proper perineal care.There were no other residents affected by this practice, however all residents had the potential to be affected.The perineal care policy and procedure has been updated. An inservice for all CNAs was held on May 6, 2011 on the proper step-by-step procedures of performing perineal care for male and female residents. Three (3) return demonstrations are required by each CNA for the Director of Nursing or her designee. The monitoring tool will be utilized an each newly hited CNA to ensure they can demonstrate proper perineal care for the male and female resident.The Director of Nursing assumes responsibility for compliance and will have each CNA return demonstrate proper step-by-step perineal care for their male and female residents. Should the CNA be unable to return demonstrate successfully three (3) times, their employment will be terminated. This monitoring tool will be utilized by the Director of Nursing or her designee on all newly hired CNAS	

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	155520	A. BUILDING 00 B. WING	04/20/2011

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CORE NURSING & REHABILITATION	909 FIRST AVE EVANSVILLE, IN47710

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	She was also questioned about the wash cloths she had provided to CNA #5 for cleansing Resident #77. She indicated she had just wet them with water and had not used any soap or periwash on them. Resident #77's clinical record was reviewed on 4/13/11 at 1:50 p.m. The record indicated she had been treated for a urinary tract infection, starting on 4/1/11. 3. During initial tour on 04/12/11 at 1:15 P.M. RN #1 indicated Resident #23 was not interviewable, required total assistance for care, and was transferred by Hoyer lift. The clinical record of Resident #23 was reviewed on 04/18/11 at 10:30 A.M. Resident #23's diagnoses included, but were not limited to, Alzheimer's, arthritis, and osteoporosis. Resident #23 was observed on 04/18/11 at 10:00 A.M. being transferred from a wheelchair to a commode by CNA [Certified Nursing Assistant] #1 and CNA #2 using a gait belt. Resident #23 was observed to be incontinent of urine, requiring an incontinence brief to be changed. CNA #1 and CNA #2 were observed to provide no incontinence care to Resident #23. The most current MDS [Minimum Data Set Assessment] dated 02/24/11 indicated		to ensury they can demonstrate proper perineal care and universal precautions. This monitoring will be ongoing. The Director of Nursing will report her monitoring of infection control to the Quality Improvement Committee at least quarterly and follow any recommendations made.	

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	that Resident #23 was severely cognitively impaired, was always incontinent, was completely dependent for toilet use, personal hygiene, and transfers. A Care Conference Summary dated 02/23/11 indicated, Resident #23 was "dependent for all care." A Care Plan updated on 02/15/11 for "Self-care deficit r/t decreased physical and cognitive ability et endurance ...Dependent for hygiene and bathing...Incontinent of Bowel and bladder with staff monitoring every 2 hours and prn [as needed] with hygiene provided as indicated...Approaches...18. Staff to monitor for incontinence every 2 hours and prn and provide hygiene as indicated." A Resident Care Information Form updated on 04/05/11 indicated, Resident #23 was "incontinent of urine and stool...provide pericare after incontinence". A Nursing Progress Note date 04/12/11 at 10:00 P:.M. indicated, "...incontinent of bowel and bladder with peri care [sic] provided by staff." An attendance roster for an inservice covering "Incontinent Care" was provided			

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	by the ADoN [Assistant Director of Nursing] on 04/18/11 at 5:05 P.M. and indicated CNA #1 and CNA #2 attended the inservice on 01/14/11. The inservice education piece included, but was not limited to, "Wipe front to back." The CNA Assignment Sheet provided by RN #1 on 04/12/11 at 1:15 P.M. indicated Resident #23 required" total care...incontinent bowel and bladder, mechanical lift for transfers". In an interview with CNA #2 on 04/18/11 at 11:00 A.M. she indicated, "Peri-care should be given if they are incontinent, after they use the bathroom, and when we change them." 4. During initial tour, on 04/12/11 at 1:20 P.M., RN #1 indicated Resident #9 was not interviewable, required total assistance for care, and was incontinent of bladder. The clinical record of Resident #9 was reviewed on 04/18/11 at 9:45 A.M. Resident #9's diagnoses included, but were not limited to, Chronic Kidney Disease and Dementia. Resident #9 was observed on 04/18/11 at 9:45 A.M. being transferred from a wheelchair to a commode by CNA			

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	[Certified Nursing Assistant] #1 and CNA #2. Resident #23 was observed to void urine while on commode. CNA #1 was observed to provide perineal care to the buttocks and rectal area without providing perineal care to the front perineal area . The most current MDS [Minimum Data Set Assessment], dated 02/21/11, indicated that Resident #9 was severely cognitively impaired, was completely dependent for toilet use, personal hygiene, and transfers. A Care Plan updated April 2011 for "Self-care deficit r/t decreased physical and cognitive ability ...Dependent for hygiene...Approaches...2. Shower two times a week and prn [as needed]." A Resident Care Information Form, updated on 04/05/11, indicated the staff would provide perineal care. In an interview with CNA #2, on 04/18/11 at 11:00 A.M., she indicated, "Peri-care should be given if they are incontinent, after they use the bathroom, and when we change them." 5. The policy and procedure for Perineal Care [no date] was provided by the Director of Nurses on 4/18/11 at 5:40 p.m. The purpose included: "To cleanse the perineal area after urination or a bowel			

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	movement to minimize the chance of infection, irritation or discomfort." Perineal care for female patients included, but was not limited to, the following: "Separate the labia and wash, rinse and dry the urethral area first with short downward strokes alternating from side to side and proceeding until the exposed area around the urethra is done" Also included in the policy and procedure: "Hands will be washed before and after procedure." "Clean bedside area as indicated." "Wash hands." The policy and procedure for Handwashing [no date] was provided by the Director of Nurses on 4/18/11 at 5:40 p.m. The policy and procedure included, but was not limited to, the following: "Appropriate fifteen (15) to twenty (20) second handwashing with soap and warm water must be performed under the following conditions: "After contact with blood, body fluids, excretions, secretions, mucous membranes or nonintact skin; After handling items potentially contaminated with blood, body fluids, excretions, or secretions; After removing gloves; Whenever in doubt..." "The use of gloves does not replace handwashing." 3.1-18(j)			
F0458 SS=E	Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.			

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	Based on observation, interview and record review, the facility failed to provide 80 square feet of room space per resident in multiple resident bedrooms, for 9 of 43 resident rooms on 1 of 3 nursing units (Rooms 106, 107, 108, 109, 110, 111, 112, 113, 114) (Unit 100). This had the potential to affect 11 of 61 residents currently residing in the facility. Findings include: 1. Resident rooms *106, *107, *108, *109, and *110 were observed set up for two residents in each room, when observed on 4/20/11 at 1:30 p.m. According to the room size certification form maintained by the facility, the rooms measured 145.12 square feet per room. Each room was certified for SNF/NF level of care. Each resident bed had a total of 72.56 square feet. 2. Resident room *111, *112, *113, and *114 were observed set up for two residents in each room, when observed on 4/20/11 at 1:30 p.m. According to the room size certification form, the rooms measure 145.12 square feet per room. Each room was certified for NF level of care. Each resident bed had a total of 72.56 square feet. On 4/12/11 at 1:00 p.m., at the facility	F0458	A room size variance has been requested from the Indiana State Department of Health on April 27, 2011 for rooms 106, 107, 108, 109, 110 which are dually certified and Rooms 111, 112, 113, 114 which are NF.There were no residents negately affected by their room size.The Administrator and Director of Nursing will continue to monitor daily to ensure compliance and safety of all residents.	05/20/2011

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	entrance conference with the Administrator, she indicated the facility currently had room size waivers and they would continue through the upcoming year. 3.1-19(l)(2)(A) 3.1-19(l)(8)			